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Tri-Service Medical Transformation – Time for a Unified Military Medical Command (USMEDCOM)

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ABSTRACT

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The current U.S. military medical service structure is redundant and inefficient. Each service trains, equips and organizes its own medical force under the direction of a Surgeon General and medical department (the Navy Bureau of Medicine and Surgery - BUMED, the Army Medical Command - USAMEDCOM, and the Air Force Medical Service – AFMS). Yet all these medical departments are interwoven in and subordinate to the Defense Health Program (DHP) and its peacetime health care delivery system – TRICARE. This paper assesses the current Department of Defense (DOD) medical support organization and proposes the development of a unified medical command (USMEDCOM) that will provide health care across the services more efficiently through the common training, organizing and equipping of a joint medical force.

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TRI-SERVICE MEDICAL TRANSFORMATION – TIME FOR A UNIFIED MILITARY MEDICAL COMMAND (USMEDCOM)

BACKGROUND

> There is duplication and even competition in the provisions of services by the Army, Navy, and Air Force. There are too many hospitals and infirmaries within easy reach of large facilities that have empty beds and not overburdened staffs. Medical specialists are too scattered—many of them are in hospitals that cannot make full use of their valuable training or skills.
>
> ? Second Hoover Commission, February 1955

The concern over duplicative and redundant military medical services has a long and noteworthy history. "In 1947, The Army Surgeon general, over the objections of his Navy colleagues, advocated a single medical service to the Congress. He believed that medical service in war, no matter how good, is more effective if it is unified."[1] General Eisenhower was even more adamant in his opposition to separate service medical departments when he opined that same year that he was staunchly against any plan for separate service Medical Corps, a concept that he judged to be ridiculous.[2] Some 56 years later, each branch of the military service continues to build, train, equip and field its own unique medical force. The Department of Defense (DOD) Military Health System (MHS) is arguably one of the largest and most complex health care organizations in the world. Its global infrastructure includes 76 military hospitals, 513 military clinics and almost 130,000 military and civilian personnel providing medical services to 8.2 million eligible beneficiaries.[3]

The MHS mission is to "maintain readiness by providing medical services and support to the armed forces during military operations and to provide medical support to their dependents and other beneficiaries entitled to DOD health care."[4] This health care benefit is extremely important for recruitment and retention of service members and ranks second in value only behind retirement as a military benefit for those currently in uniform.[5] Moreover, this mission statement illustrates the complex, dual environment of peacetime operations and wartime readiness in which the MHS functions and provides health services around the world to soldiers, sailors, airmen, marines, retirees and their family members. To its credit, the MHS is lightheartedly singled out as 'the only HMO (health care maintenance organization) that goes to war.'

Given the importance and complexity of the health care mission, it has been the subject of intense scrutiny, especially concerning the redundancy of multiple medical corps, since World War II. In February, 1949 the JCS (Joint Chiefs of Staff) unanimously recommended that the

Secretary of Defense immediately initiate studies and actions to establish a unified medical force for the support of the three services.[6] A subsequent shortfall in health care for military dependents and the inefficiency of the existent medical structure in the 1950s resulted in further review by the second Hoover Commission. The primary recommendation of that study was that the medical and hospital services of the three Armed Services could be vastly improved through closer coordination and integration.[7] This recommendation certainly fell short of a mandate for consolidation of the services' medical organizations but nonetheless endorsed greater uniformity and cooperation to improve health care delivery. In fact, a study later that decade to examine the feasibility of a single military medical manager found that cooperation and coordination among the services had greatly improved and that there was no real problem in the delivery of military health care.[8] That opinion remained dominant until 1970 when a Presidential Blue Ribbon Panel "recommended the establishment of an Office of Director of Defense Medicine and Health that would be responsible for eliminating waste, duplication, and redundancy by reviewing and approving budgets and manpower for all DOD health programs, and by consolidating all programs for research, supply and equipment, professional services, intelligence, construction, and other matters."[9] Despite this strong directive, no action was taken to establish the office or unify the redundant medical system.

The Office of Management and Budget, DOD and the Department of Health, Education and Welfare conducted another major interagency study of military health care in 1975. At that time, the concern was focused on escalating CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) costs, physician retention across the services, quality of health care planning and management, and overhead costs in DOD.[10] Two key recommendations were drawn from this study:

- The size and composition of the medical force should be based upon mobilization, contingency, and other essential force requirements, valid teaching or training needs, and low marginal costs.
- A central entity should coordinate planning.[11]

The first recommendation provided the framework for assessing the needs of each service to maintain its medical force structure. The second recommendation resulted in the establishment of the Defense Health Council (DHC) in 1977 as a central point for health services plans and policies and to advise the Assistant Secretary of Defense for Health Affairs (ASD(HA)). The Defense Health Council never did achieve its intended goal to efficiently centralize and fully coordinate medical planning across the services. It acted only as an advisory and coordinating body and lacked the authority for decision making and resource allocation.[12]

Not surprisingly therefore, the military health care system received low marks again in a House Appropriations Committee Report in 1981. The committee determined that:

- ASD(HA) did not have the capacity to monitor the military departments.
- ASD(HA) lacked direct line authority over the military medical activities.
- DOD had rejected all previous recommendations for central management of medical programs.
- DOD had defined its medical mobilization requirement but not its peacetime medical mission.
- DOD lacked a consistent basis for determining resource requirements in the direct care system.
- The military services lacked standard criteria for staffing medical facilities.[13]

These six issues continue to plague the health care delivery capability today. Moreover, they are indicative of a protracted history of recalcitrance, resistance to change and parochialism.

Recently, two more external studies have again raised the call for a unified medical command. The Healthcare Quality Initiatives Review Panel (HQIRP) was chartered in Congress in 1999 to review the Defense Health Program with a focus on nine specific issues (professional education, "centers of excellence," National Practitioner Data Bank compliance, licensing and credentialing, quality management reporting, communication with beneficiaries, the quality management program, laboratory standards, and accuracy in patient data and information). One year later, the advisory committee reported that although the quality of health care delivered throughout the Military health System was generally satisfactory, that core problems were evident however in global processes, uniformity and stability in resource acquisition across the service medical departments.[14] These core problems were deemed so significant that they superceded the nine areas of concern directed by Congress and resulted in the panel's recommendation (among others) that a unified military medical command be established. Only then could the Military Health System adequately address resource acquisition and management, system processes, and quality oversight of the managed care program.[15] Later, in June 2001, the consulting group KMPG reported to the Defense Medical Oversight Committee (DMOC) that unity of effort across the services must be enhanced, a joint command structure should be adopted, and accountability and responsibility in the Military Health System should be clarified through a more coherent command structure.[16] Time and again, studies have promoted, directed or supported the amalgamation of the three services' medical departments into one unified command and control organization. Unfortunately, the Military Health System continues to maintain the status quo instead of transforming.

The current MHS structure therefore, remains both redundant and inefficient. Each service trains, equips and organizes its own medical force under the direction of a Surgeon General and a separate medical department (the Navy Bureau of Medicine and Surgery - BUMED, the Army Medical Command - USAMEDCOM, and the Air Force Medical Service – AFMS). Yet all these medical departments are interwoven in and subordinate to the Defense Health Program (DHP) and obtain peacetime medical care through a unified managed care program called TRICARE. Additionally, Secretary of Defense Rumsfeld has described the current DHP bureaucracy as redundant with four different agencies in control of health care delivery.[17] He therefore ordered a complete restructuring and transformation of the Military Health System by fiscal year 2003.[18] Will this call to transform go unheeded like all the others dating back to World War II? The MHS has much work to do and will doubtless fail to meet this impending deadline. That does not infer however, that DOD should curtail any effort to transform the military health system.

Accountability for the DHP rests with the Assistant Secretary of Defense for Health Affairs (ASD(HA)).[19] The Assistant Secretary (HA) is also the principal health services advisor to the Secretary of Defense, the Deputy Secretary and the Undersecretary of Defense for Personnel and Readiness on health policies, programs, and activities.[20] His responsibilities include "establishing policies, procedures, and standards for DOD medical programs; preparing a unified medical program and budget with funding for military accounts except military personnel; and presenting and justifying the medical program and budget to DOD and congress."[21] This funding for the DOD medical program includes operation and maintenance, procurement and the CHAMPUS appropriations accounts. The Assistant Secretary (HA) is limited by law however, in his control over medical personnel.[22] In fact, the single Defense medical appropriations account does not currently include funds for active and reserve military medical personnel.[23] ASD(HA) also lacks authority to direct personnel changes in the chain of command in any military medical department or in personnel assigned to that command.[24]

Although the Assistant Secretary of Defense for Health Affairs has the responsibility and accountability for the Defense Health Program, he does not maintain direct line authority over the three military medical activities or the Service Surgeons General. In contrast, the Service Surgeons General exercise Title 10 responsibilities for the care of military personnel along with the manning, equipping, and training of the medical force.[25] They also are the principal medical advisors to the respective Service Secretary and Service Chief. An extract from the Army Surgeon General's duties and responsibilities establishes that he will "work closely with the Assistant Secretary of Defense (Health Affairs) and the TRICARE Management Activity (TMA)

to build an integrated health care delivery system with our Sister Services."[26] Finally, the Director, TRICARE Management Activity reports to the Under Secretary of Defense for Personnel and Readiness through the Assistant Secretary of Defense (Health Affairs) with the responsibility for managing the TRICARE program and "managing and executing the Defense Health Program (DHP) appropriation and the *DOD Unified Medical Program* (emphasis added).[27] The TMA was established as a DOD Field Activity in 1998.[28]

In summary, the MHS structure cascades loosely from the Under Secretary of Defense for Personnel and Readiness to the Assistant Secretary of Defense (Health Affairs) to the TRICARE Management Agency (TMA) with coordination through the separate military services and the three Surgeons General with their distinct medical departments to the deployable medical forces serving under the combatant commanders, with the goal of delivering optimal health care in peace and war at a cost of $24.2 billion in fiscal year 2002. This paper assesses the current DOD medical support organization and proposes the development of a unified medical command (USMEDCOM) that will transform the Military Health System to provide health care across the services more efficiently through the common training, organizing and equipping of a joint medical force under one functional combatant commander.

IMPETUS FOR CHANGE

Although recommendations for a single unified medical command have been made countless times before, they have largely been dismissed by the services.[29] Service "uniqueness" along with the distinct nature of each service's medical mission, structure and requirements were cited as justification for continuing the status quo.[30] However, the service medical organizations are in many respects more similar than they are unique. The following list summarizes those common and unique factors:

- Common Factors[31]
    - All three services share a mission -- to preserve the human resource of the Armed Forces.
    - All three services deal in medical standards for military service, the prevention of disease, and the provision of treatment and evacuation of the ill and injured.
    - All three services have a common professional manpower source -- medical, dental, nursing, as well as other social and scientific schools and colleges.
    - The philosophy of disease and injury prevention and therapy is generally common throughout the U.S.
    - The standards of clinical performance are the same for all the military services.

- Medical treatment facilities employ common construction standards.
- The medical services share a common technical language.
- There are common administrative procedures and language.
- There is a common source of medical supplies and equipment.
- Usage of major patient movement means (medical evacuation) both intra- and inter-theater is standardized.
- There is joint staffing of selected medical facilities, particularly in teaching and research activities.
- There is a history of loaning medical personnel from one service to another based upon greater need.
- There are common assignments to medical sections of major unified or combined headquarters.
- There is common usage of fixed treatment facilities by military personnel, family members and other authorized beneficiaries regardless of service identity.
- All authorized beneficiaries regardless of service identity use TRICARE (formerly CHAMPUS).
- There are common legal, religious, Inspector General, public affairs, and administrative needs in operating fixed treatment facilities.
- There are common medical information needs in operating and managing health care services.
- There are numerous cooperative arrangements already operating successfully.
- The services share a common patient base.

- Unique factors[32]
  - The requirement for each service to have a medical apparatus that is designed, staffed, armed with proper doctrine, trained and integrated into the parent service for its peculiar mission.
  - Organizational and administrative factors arising from changes that might be required in personnel, training, staff and command relationships at the Defense and Military department levels.
  - Management of the medical aspects of the Reserve force and the National Guard.
  - The role of the military medical services in support of civil defense (now Homeland Defense).

- Requirement of a service or commander to have command or control of an asset already a part of its organization to ensure accomplishment of an assigned mission.
- Service history, customs, traditions, prejudices, loyalties, and royalties

Based upon the factors above, logic dictates that the MHS should exploit and build upon the overwhelming commonalities and form a unified medical organization. To calm any fear that service specific missions would be jeopardized by a lack of medical support, the new medical structure should maintain the capability to support an absolute minimum of any service-derived unique missions. That was the conclusion of the Senate Armed Services Committee (SASC) in 1982 when it proposed the establishment of a Defense Health Agency (DHA) and suggested that the roles of the Assistant Secretary for Health Affairs and the Surgeons General be redefined. The proposal delineated that the ASD(HA) would continue to set health policy for the Department of Defense; that the DHA director would operate the worldwide health delivery system; and that the Surgeons General would assess the combat readiness of medical support in the operating and field forces and would prepare for wartime medical mobilization.[33] At the time of this proposal, successful model programs based on consolidation and a unified command structure were readily available within DOD. Notably, the Defense Logistics Agency (DLA) and the Defense Intelligence Agency (DIA) were examples of proven consolidation of a military function across the services into a single command and control structure.[34]

Furthermore, this SASC proposal would not have totally usurped the services role in providing health care functions. The SASC envisioned that the services would continue to:

- Direct career development and personnel management of military health services personnel.
- Develop doctrine for operational medical support.
- Design, acquire, or plan for the use of deployable medical support systems.
- Generate and validate requirements for manpower, facilities, equipment, supplies, and research and development needed in wartime.
- Conduct enlisted training.
- Plan, program, or budget for functions that are the responsibility of the Surgeons General.
- Provide service-unique operational medical support.
- Manage all medical research and development in conjunction with Under Secretary of Defense (Research and Engineering).[35]

This proposed Defense Health Agency structure and functions resemble the current military health system with the exception that the DHA is now called the TRICARE Management Activity (TMA). It represented progress at the time but still fails to meet the goal of a single, unified medical command structure. It unfortunately also perpetuated the crossed lines of command and control, wherein the Surgeons General would continue to train and provide medical personnel to deployable units but not have command over them. As evidence, "The lines of authority and accountability between hospital commanders, the services, the Service Surgeons General and the Assistant Secretary of Defense (Health Affairs) are complicated and sometimes conflict. Funding of the MHSS (Military Health Service System), for example, is controlled by two different entities."[36] That remains true today.

However, the current constrained budget environment gives greater emphasis to the need for overarching change in the tri-service medical structure and operations, with the goal of significant consolidation, reduction of overhead and the elimination of redundancy. The Military Health System budget has been growing at an alarming rate. In the 1980s, a period of unparalleled medical inflation for our nation, MHS costs increased 225 percent while civilian health care costs rose 166 percent.[37] Medical inflation is also projected to continue to outpace general inflation for the near term with an estimate of an 11-12 percent increase in fiscal year 2003 and continued double-digit rates for at least two more years.[38] The incredible medical cost increase was a primary factor for the implementation of a managed care model (formerly CHAMPUS, 1966-1991; now TRICARE) for the Military Health System.

Also during the 1980s, the medical portion of the DOD budget doubled, from 3 percent to 6 percent of total military expenditures.[39] Unforecasted medical expenses have repeatedly cut into DOD operations and maintenance funds as the unfortunate bill payer. During the period 1994-2001, DOD required supplemental appropriations from Congress in six of those eight fiscal years due to higher than expected medical costs.[40] Given the current economic slump, the cost of the war on terrorism and the new budgetary era of limited discretionary funds, any additional medical costs could significantly detract from other high priority military programs like readiness, quality of life and transformation. Unfortunately, Defense Health Program spending has yet to be arrested. From 1997 to 2003, the DHP total obligation authority increased 18 percent.[41]

The budget woes are further complicated by the introduction of a new program for retired service members and their families – TRICARE For Life (TFL). This worthwhile program that fulfills the unwritten promise of medical benefits for life for retired service members incurred an $8.1 billion initial cost in fiscal year 2003 alone for payment into an accrual fund for future year

benefits.[42] The anticipated recurring cost of TRICARE For Life is $6 billion annually with the projection that one out of every five health care beneficiaries will be an over-65 retiree or family member by 2007.[43] To achieve fiscal efficiency and solvency, this program may be the needed catalyst for radical transformation of the medical force. Consolidation alone is unlikely to reap sufficient budgetary savings to fund TRICARE For Life. A conservative savings projection would likely be in the 10 to 20 percent range or $2 to $4 billion annually. Will the lure of this budgetary offset drive the change to a new command structure now or will the MHS delay, only to succumb later to greater budgetary constraints and political pressure? Such was the case with the British military. Similar discussion and debate on a unified medical command also occurred there since World War II without action until the mid-1990s when costs, recruitment and retention problems compelled the British military to centralize personnel, training and medical functions under one department.[44]

Table 1 below indicates that the defense medical costs have exceeded the record spending level of the 1980s. The projected budget for next year (excluding TFL benefits) also shows only a modest decline in the total spending and as percentage of the entire DOD budget.[45]

	DOD	**MHS**	**% MHS/DOD**
FY2001	291	19.1	6.6%
FY2002	296	24.2	8.2%
FY2003	379	19.8	5.2%
	in billions		

TABLE 1

That modest downturn is little cause for celebration however. For a global perspective, consider that the level of defense spending in fiscal year 2000 for health care alone ($18 billion) far surpassed the total defense spending that year of individual countries like Italy, Brazil and South Korea and almost equaled that of Saudi Arabia.[46]

Another major reason for transformation is to better manage the most critical resource – our people. Secretary of Defense Rumsfeld has pointed out that "one out of every five officers in the United States Navy is a physician."[47] Although not spoken derisively, it is a concern shared by other senior leaders who have expressed trepidation with the number of overall medical personnel in the military. On numerous occasions I have heard the anecdotal remark that the Army has more nurses than infantrymen. That may be true given that across DOD, some 91,000 uniformed medical personnel support an active military of 1.4 million, a ratio of 1 medic per 16 soldiers, sailors, airmen or marines.[48] A more accurate comparison however would include the broader measure of total beneficiaries (8.2 million active duty, family

members and retirees) to both military and civilian medical personnel (130,000) to yield a ratio of 1 medic per 63 health care beneficiaries.

Despite this abundance of medical personnel however, the MHS continues to endure critical shortages of physician specialties, nurses and other high demand medical technicians. Recurring localized shortfalls are exacerbated by an inability to manage personnel resources from a corporate perspective and by infrastructure excess and overlap in certain areas. For example, the National Capital Area (NCA) is served by three service medical centers and 26 military clinics while San Antonio, Texas is supported by two medical centers and numerous other clinics.[49] Moreover, resource sharing between these facilities is based on informal, non-binding agreements rather than fixed, long term contracts that could reduce overhead, improve allocation of valuable resources and enhance overall readiness.[50]

These examples depict the fundamental lack of unity of effort from a Defense Health Program perspective that almost certainly guarantees the sub-optimization of precious medical resources. It also exemplifies the programmatic error whereby the services do not generally take into account other services' locally or regionally available resources when allocating military treatment facility assets.[51] The DOD Inspector General found the same management shortfall in its 2001 review of the Military Health System Optimization Plan. This study recommended that the optimization plan "include a Military Health System-wide methodology for allocating medical personnel during peacetime, regardless of Military Department affiliation, to achieve maximum efficiency and productivity."[52] Both the Navy and the Air Force agreed with the recommendation but the Army branded it "unworkable," preferring to rely on the established ad hoc resource allocation sharing arrangement instead.[53]

This critical program error not only occurs on the fixed treatment facility side of health care delivery but is also found in the field medical force. An example from Desert Storm was the inadequate number of helicopters available for medical evacuation because the Navy did not levy that requirement upon the Army or Marine Corps.[54] Fortunately, the casualty rates did not stress the evacuation system to the breaking point as a result of this recurring pattern of resource mismanagement and reliance on ad hoc support agreements.

Management processes within the Military Health System also require improvement. Another recent DOD Inspector General report cited "weak management controls and little consistency and standardization of policies and procedures…at 13 sites the staff visited."[55] Inconsistency appears to be a corporate strategy as each service maintains its own requirements determination and resource allocation approach, which renders any productivity comparison across the services difficult, if not impossible.[56] The Army relies on results from the

Total Army Analysis model to determine overall wartime medical requirements with the Total Army Medical Department Personnel Structure model.[57] The Army Medical Department uses another model, the Automated Staffing Assessment model for determining personnel needs for fixed medical treatment facilities. The Navy also uses multiple models to determine wartime and peacetime medical requirements.[58] The Air Force is the lone service that relies on the DOD sizing model to establish its medical force structure requirements.[59] Progress has been made in this area with all the services agreeing under the DOD reengineering initiative to adopt this common requirements model, the DOD sizing model. The implementation deadline for transition to the DOD model is unknown.

How and where medical personnel are trained is another area ripe for transformation. Each service maintains its own medical skills training base for the instruction of new recruits. The Navy produces independent duty corpsmen to support autonomous Marine and shipboard operations. At one time, that program was the gold standard for medic training. Today however, the Army develops emergency medical technician (EMT) qualified medics whose skills parallel that of any naval corpsmen. Certainly, the military health system could benefit from a consolidated training program for all its medics by reducing overhead and amalgamating the best of each service's training program to produce a more highly skilled front line medic or treatment facility medical specialist. The same benefit may accrue through consolidation in physician residency training and graduate medical education programs at the 15 medical centers.[60] Consider for example that all three services maintain separate training programs for their flight surgeons and yet they are founded on the same basic tenets of aviation medicine and flight physiology. This specialty exemplifies a variety other medical fields that could be consolidated based on area of medical expertise rather than along service lines.

EVIDENCE OF TRANSFORMATION

We have however made some operational progress toward unifying the medical support structure. Although these measures fall short of the total transformation proposed, they are positive steps that bolster the case for the quantum leap to a unified medical command. TRICARE is an excellent example of a unified program to provide peacetime health care and to rein in cost. Its regional framework provides a potential test bed for the unified medical command structure. In health service logistics, DOD has established the Single Integrated Medical Logistics Manager (SIMLM) for each theater. The Army Medical Department exercises that function in Korea, Southwest Asia, Southern Command and Europe.[61] Medical logisticians will operate integrated military and civilian distribution systems for maximum responsiveness

instead of their service specific, stove piped distribution networks.[62] This function could ideally be expanded worldwide under a unified medical command to better support the Joint Vision 2020 tenet of focused logistics.[63]

The services have also made great strides in the development of Joint Doctrine. The overarching guidance of Joint Publication 4-0, Doctrine for Logistic Support of Joint Operations, stimulated the publication of additional, subordinate doctrine on health service support, patient movement, and health service logistics support. Joint exercises however, often fail to fully exercise or even include medical organization or functions with their emphasis on the combatant force. Large scale inter-service exercises that stress the deployable medical infrastructure do not exist.[64] Common sense dictates that to operate successfully as a joint force in wartime, the medical services must fully train and rigorously exercise jointly in peacetime. A unified medical command could coordinate directly with combat commanders to ensure the fidelity of medical play in future joint and combined exercises.

DOD has also established a Joint Force Health Protection (FHP) program that "requires maximizing the effectiveness of the services' medical elements through jointly coordinated, comprehensively planned, and mutually supportive medical operations."[65] Examples of future critical success factors for this program include the standardization of joint combat medic/corpsmen core competencies, standardization of forward resuscitative surgery units and skills and the development of joint doctrine for theater hospital operations.[66] As previously mentioned, combined training of medical personnel could produce a tremendous benefit in both resources saved and the quality of medic produced. However, DOD must leap forward from these initial accomplishments in joint doctrine and force health protection to consolidation of a unified medical command.

ROAD AHEAD

Given the budgetary conundrum, congressional pressure, the operational edict for jointness and the incremental progress toward a joint medical force, the operative transformation question seems not to be if but when and how? Will the Military Health System and its senior leaders determine its future or will that decision rest outside the MHS in a congressional or Department of Defense directive? Transformation rightfully causes organizational strife and discord since there is an inherent human resistance to change. This is not insurmountable however and there is ample evidence of successful transformation in the business world. A potential, although not perfect, blueprint for our reorganization is evident in another DOD institution, the U.S. Transportation Command (USTRANSCOM).

There are many parallels between the roles, responsibilities and mission of USTRANSCOM and the Military Health System. Prior to the establishment of USTRANSCOM, each service was independently involved in transportation support to the combatant commanders. Each service likely viewed its individual contribution as both necessary and unique to supporting both the warfighter and the parent service transportation requirements. Each service likely held a rich military heritage and service identity. One supposes though that like the MHS, there were many more similarities among the tri-service transporters than differences. The formation of USTRANSCOM in 1987 consolidated the Transportation Component Commands (TCC) of Air Mobility Command (AMC), Military Sealift Command (MSC) and Military Traffic Management Command (MTMC) into one functional combatant command with global reach. USTRANSCOM aptly fit the definition of a unified command as one formed by the President through the Secretary of Defense for "broad continuing missions under a single commander and composed of forces from two or more Military Departments."[67] Unlike most combatant commanders (i.e., Central Command), the Commander, U.S. Transportation Command does not have a responsibility for a specific geographic area or region. Instead he maintains control and assignment of his forces deployed in and through a combatant commander's area.[68]

The establishment of USTRANSCOM was not problem free however and provides useful lessons learned for a unified medical command. Initially, the USTRANSCOM commander's authorities were restricted to a wartime role with the services maintaining their single-manager peacetime charters for their respective transportation modes.[69] Consequently, the services continued daily operations much as they had before USTRANSCOM stood up. The services controlled their own funds, procurement, maintenance and operational control of forces.[70] These crossed lines of command and resource allocation resulted in a new, expanded charter for USTRANSCOM in 1992. Now the commander had both the peacetime and wartime authority over the Transportation Component Commands and all their transportation assets except those that were service unique or assigned to other theater combatant commanders.[71]

USMEDCOM STRUCTURE

The Military Health System must establish a functional combatant command to provide health support in the air, on land, and sea. Unity of effort demands that one commander exercise combatant command (command authority) over assigned forces with direct responsibility through the Secretary of Defense to the President for the accomplishment of assigned missions and the readiness of the command.[72] The USMEDCOM Commander should

therefore be designated a four-star general billet to be primus inter pares with the other combatant commanders. Full accountability for the entire Defense Health Program should be vested in this commander. Now is the time to finally unite the responsibility for both health appropriations and medical manpower under one entity. The Assistant Secretary of Defense (Health Affairs) would retain only his policy and advisor role to the Secretary of Defense.

To avoid the problems experienced by USTRANSCOM, the new structure should be founded on a regional basis that supports the Unified Command Plan (UCP) geographic areas of responsibility rather than simply maintaining an air, sea and land medical component configuration. Commander, USMEDCOM would exercise command and control of all medical forces and resources through subordinate regional medical commanders. These regional commanders would also function as the Joint Surgeon for the theater combatant commander. The regional medical commander would thus maintain responsibility and accountability for both peacetime and wartime health care delivery and readiness throughout his area of responsibility. This approach provides the regional medical commander with total visibility of available resources and facilitates formal resource sharing agreements between subordinate field organizations and fixed treatment facilities within his area. The end result is a simplified and meaningful chain of command, a single point of contact for health services in the theater and potential economies of scale savings through consolidation.

The Service Surgeons General would cease to exist in their present form. Instead, the USMEDCOM should incorporate those flag rank billets as various functional deputy commanders. This proposal could include deputy command responsibilities for personnel, training, logistics, medical intelligence, operations, managed care, and communication and information management. The intent is not to simply create another layer of bureaucracy above the Surgeon General level from the current structure but to radically modify the Military Health System to reduce redundancy, improve resource allocation and management, and overlay a functional vice service specific organizational structure.

Resource allocation would be further enhanced by the incorporation of the DOD sizing model to compare workload with requirements across the force. The unified medical commander could then carefully evaluate the efficiency of the health care delivery system by region and redistribute personnel wherever needed based on this common, relevant operational picture and his future vision. Regional medical commanders would routinely (quarterly) justify their workload and productivity metrics against manpower and budget allocations. They also would present an annual combat health service support plan, designed in concert with the theater operational plan, for USMEDCOM review.

Medics (generic term for all medical personnel) would simply be “medics.” After enlisted basic training at any service’s basic training station, they would lose any semblance of service specific affiliation and instead be fully integrated into the USMEDCOM during their advanced individual training or officer basic course. The potential exists that these medics could even be issued a unique uniform but at a minimum they would wear the USMEDCOM patch as assigned service members of any combatant command. Direct care providers would be recruited for the USMEDCOM and not for any particular service. Personnel management, to include promotion, education, and assignments, could be consolidated under the Deputy Surgeon General (Personnel). The Army currently maintains its own personnel management system for medical department personnel that could serve as an organizational model. Of course, an individual’s preference for an air, ground or sea duty billet would be taken into consideration for assignment purposes. I envision a military medical system wherein medics could serve easily on board a ship, followed by service in an Army field unit and then on to duty in a fixed facility. This proposal would run counter to a potential change in the Army personnel system in which whole unit replacement would prevail over the current individual soldier replacement model.

Service specific medical units and missions will be rigorously examined with the goal of minimizing them to the absolute smallest number. Special Forces units may have a justifiable claim to uniqueness but other missions claiming uniqueness based solely on the “air, sea or ground environment” would not merit the establishment of service specific medical units. This battle for a new service and medical culture will be exceptionally difficult. The benefit of a unified medical command however is even more exceptional.

Consolidation across services would enable the MHS leadership to examine the TRICARE Management Activity (TMA) functions for redistribution. Since the USMEDCOM commander would now bear full responsibility for the Defense Health Program and the DOD Unified Medical Program, many health care management functions could be absorbed by the regional subordinate commands or redefined so that TMA only provides administrative and contract support (claims management, benefits guidance to service members, enrollment assistance, etc.). The key again is unity of effort and linking responsibility with accountability in the unified medical commander.

CONCLUSION

> In nearly four decades this issue has been studied at least ten times. The Military Departments have continued to oppose creation of a central health management structure. In their judgment tri-service coordination is preferable to consolidation. The preponderant judgment of outside study groups has favored consolidation of at least the common health care functions. Based on this

> history, the Study Team believes the Military Departments will continue to oppose consolidation and future studies will continue to consider consolidation of the fixed site medical facilities as essential to efficient operation of the Military Health Care System. This issue is unlikely to go away until the fundamental inefficiencies with the Military Health Care System are corrected.
>
> ? DOD Health Studies Task Force, 1983

Twenty years after the task force rebuke above, the services are still encumbered by a legacy medical force with a complicated and sometimes counterproductive command and policy chain, an inconsistent resource allocation methodology, and an increasingly costly and redundant health care infrastructure. Reform of the Department of Defense infrastructure is the key to a successful transformation strategy.[73] Given the current focus on Transformation, the Military Health System has a window of opportunity to ensure its relevance by establishing a USMEDCOM for tri-service readiness and global medical support. As with the Army effort, this transformation is a journey, not a destination. It is a journey however that must be launched now at the risk of losing relevance as the premier medical force and instead be viewed as an expensive resource behemoth ripe for extinction.

This command will establish unity of effort, maximize resources, and streamline confusing, multiple chains of command. Both TRICARE and the functional combatant command structure of U.S. Transportation Command (USTRANSCOM) offer examples for proof of principle testing of a unified medical command. The subsequent budgetary savings should then be invested in better training and equipping of our medical units and facilities. A new USMEDCOM is the best guarantor to meet the expectation that "the military health system of the future must support the evolving national military strategy and the strategies and tactics of the 21st century."[74]

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GLOSSARY

AFMS	Air Force Medical Service
AMC	AIR Mobility COMMAND
ASD(HA)	Assistant Secretary of Defense (Health Affairs)
BUMED	Bureau of Medicine and Surgery
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
DHA	Defense Health Agency
DHC	Defense Health Counsel
DHP	Defense Health Program
DIA	Defense Intelligence Agency
DLA	Defense Logistics Agency
DMOC	Defense Medical Oversight Committee
EMT	Emergency Medical Technician
FHP	Force Health Protection
HMO	Healthcare Maintenance Organization
HQIRP	Healthcare Quality Initiatives Review Panel
JCS	Joint Chiefs of Staff
MHS	Military Health System
MHSS	Military Health Service System
MSC	Military Sealift Command
MTMC	Military Traffic Management Command
NCA	National Capital Area
SASC	Senate Armed Services Committee
SIMLM	Single Integrated Medical Logistics Manager
TCC	Transportation Component Command
TFL	TRICARE For Life
TMA	TRICARE Management Agency
UCP	Unified Command Plan
USAMEDCOM	U.S. Army Medical Command

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